

907 KAR 10:012. Inpatient hospital service coverage.

RELATES TO: KRS 205.520, 42 U.S.C. 1395ww, 1396, 1396a, 1396b, 1396d, 1396r-4, 42 C.F.R. 440.10, Pub.L. 111-148

STATUTORY AUTHORITY: KRS 194A.010(1), (2), 194A.030(2), 194A.050, 205.520(3), 42 C.F.R. 440.10, 440.210, 440.220, 42 U.S.C. 1396, a, b, d, r-4, Pub.L. 111-148

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services has responsibility to administer the Medicaid Program. KRS 205.520 authorizes the cabinet, by administrative regulation, to comply with any requirement that may be imposed or opportunity presented by federal law for the provision of medical assistance to Kentucky's indigent citizenry. This administrative regulation establishes the provisions relating to inpatient hospital services for which payment shall be made by the Medicaid Program for a hospital inpatient service.

Section 1. Definitions. (1) "Acute care hospital" is defined by KRS 205.639(1).

(2) "Critical access hospital" means a hospital meeting the licensure requirements established in 906 KAR 1:110 and designated as a critical access hospital by the department.

(3) "Department" means the Department for Medicaid Services or its designee.

(4) "Emergency" means a condition or situation which requires an emergency service pursuant to 42 C.F.R. 447.53.

(5) "Federal financial participation" is defined by 42 C.F.R. 400.203.

(6) "Hospital-acquired condition" means a condition:

(a)1. Associated with a diagnosis code selected by the Secretary of the U.S. Department of Health and Human Services pursuant to 42 U.S.C. 1395ww(d)(4)(D); and

2. Not present upon the recipient's admission to the hospital; or

(b)1. Which is recognized by the Centers for Medicare and Medicaid Services as a hospital-acquired condition.

(7) "Long-term acute care hospital" means a long term care hospital that meets the requirements established in 42 C.F.R. 412.23(e).

(8) "Medical necessity" or "medically necessary" means that a covered benefit is determined to be needed in accordance with 907 KAR 3:130.

(9) "Never event" means:

(a) A procedure, service, or hospitalization not reimbursable by Medicare pursuant to CMS Manual System Pub.L. 100-03 Medicare National Coverage Determinations Transmittal 101; or

(b) A hospital-acquired condition.

(10) "Nonemergency" means a condition or situation which does not require an emergency service pursuant to 42 C.F.R. 447.53.

(11) "Psychiatric hospital" means a hospital meeting the licensure requirements established in 902 KAR 20:180.

(12) "Rehabilitation hospital" means a hospital meeting the licensure requirements established in 902 KAR 20:240.

Section 2. Prior Authorization. To be covered by the department:

(1) Prior to a nonemergency admission, including an elective admission or a weekend admission, the department shall have made a determination that the nonemergency admission was:

(a) Medically necessary; and

(b) Clinically appropriate pursuant to the criteria established in 907 KAR 3:130; and

(2) Within seventy-two (72) hours after an emergency admission, the department shall have made a determination that the emergency admission was:

- (a) Medically necessary; and
- (b) Clinically appropriate pursuant to the criteria established in 907 KAR 3:130.

Section 3. Covered Admissions. The department shall reimburse for an admission primarily indicated in the management of acute or chronic illness, injury or impairment, or for maternity care that could not be rendered on an outpatient basis.

Section 4. Noncovered Services. Inpatient hospital services not covered shall include:

(1) The department shall not reimburse an acute care hospital reimbursed via a diagnosis-related group (DRG) methodology, a critical access hospital, a long-term acute care hospital, a psychiatric hospital, a rehabilitation hospital, or a Medicare-designated psychiatric or rehabilitation distinct part unit for the following:

(a) A service which is not medically necessary including television, telephone, or guest meals;

(b) Private duty nursing;

(c) Supplies, drugs, appliances, or equipment which are furnished to the patient for use outside the hospital unless it would be considered unreasonable or impossible from a medical standpoint to limit the patient's use of the item to the periods during which he is an inpatient;

(d) A laboratory test not specifically ordered by a physician and not done on a preadmission basis unless an emergency exists;

(e) Private accommodations unless medically necessary and so ordered by the attending physician;

(f) The following listed surgical procedures, except if a life-threatening situation exists, there is another primary purpose for the admission, or the admitting physician certifies a medical necessity requiring admission to a hospital:

1. Biopsy: breast, cervical node, cervix, lesions (skin, subcutaneous, submucous), lymph node (except high axillary excision), or muscle;

2. Cauterization or cryotherapy: lesions (skin, subcutaneous, submucous), moles, polyps, warts or condylomas, anterior nose bleeds, or cervix;

3. Circumcision;

4. Dilation: dilation and curettage (diagnostic or therapeutic nonobstetrical); dilation or probing of lacrimal duct;

5. Drainage by incision or aspiration: cutaneous, subcutaneous, or joint;

6. Pelvic exam under anesthesia;

7. Excision: bartholin cyst, condylomas, foreign body, lesions lipoma, nevi (moles), sebaceous cyst, polyps, or subcutaneous fistulas;

8. Extraction: foreign body or teeth;

9. Graft, skin (pinch, splint or full thickness up to defect size three-fourths (3/4) inch diameter);

10. Hymenotomy;

11. Manipulation and reduction with or without x-ray; cast change: dislocations depending upon the joint and indication for procedure or fractures;

12. Meatotomy or urethral dilation, removal calculus and drainage of bladder without incision;

13. Myringotomy with or without tubes, otoplasty;

14. Oscopy with or without biopsy (with or without salpingogram): arthroscopy, bronchoscopy, colonoscopy, culdoscopy, cystoscopy, esophagoscopy, endoscopy, gastroscopy, hyster-

oscopy, laryngoscopy, laparoscopy, peritoneoscopy, otoscopy, and sigmoidoscopy or proctosigmoidoscopy;

15. Removal; IUD, fingernail or toenails;

16. Tenotomy hand or foot;

17. Vasectomy; or

18. Z-plasty for relaxation of scar or contracture.

(g) A service for which Medicare has denied payment;

(h) An admission relating only to observation or diagnostic purposes; or

(i) Cosmetic surgery, except as required for prompt repair of accidental injury or for the improvement of the functioning of a malformed or diseased body member.

(2) The department shall not reimburse an acute care hospital reimbursed via a DRG-methodology pursuant to 907 KAR 10:825 for treatment for or related to a never event.

(3) A hospital shall not seek payment for treatment for or related to a never event through:

(a) A recipient;

(b) The Cabinet for Health and Family Services for a child in the custody of the cabinet; or

(c) The Department for Juvenile Justice for a child in the custody of the Department for Juvenile Justice.

(4) A recipient, the Cabinet for Health and Family Services, or the Department for Juvenile Justice shall not be liable for treatment for or related to a never event.

Section 5. Federal Financial Participation. A provision established in this administrative regulation shall be null and void if the Centers for Medicare and Medicaid Services:

(1) Denies federal financial participation for the provision; or

(2) Disapproves the provision. (2 Ky.R. 101; eff. 9-10-1975; 7 Ky.R. 857; eff. 6-3-1981; 8 Ky.R. 939; 9 Ky.R. 223; eff. 8-24-1982; 10 Ky.R. 499; eff. 3-1-1984; 12 Ky.R. 366; eff. 10-8-1985; Recodified from 904 KAR 1:012, 5-2-1986; 16 Ky.R. 260; eff. 9-20-1989; 1079; eff. 1-12-1990; 18 Ky.R. 525; eff. 10-6-1991; 27 Ky.R. 245; 1264; eff. 11-17-2000; 33 Ky.R. 576; 1366; 1548; eff. 1-5-2007; 37 Ky.R. 548; 1446; eff. 12-1-2010; Recodified from 907 KAR:1:012, 5-3-2011.)